



Mike Huckabee
Governor

State of Arkansas SOCIAL WORK LICENSING BOARD

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Troylene Jones
Executive Director

VERIFICATION OF SUPERVISION FORM

(Complete when applying for LCSW licensure.)

Name of Supervisee _____ License No.: _____

Name of Supervisor: _____ License No.: _____

Were you and the LCSW supervisor employed at the same agency at the time of supervision?
Yes _____ No _____

If no, the agency director where you were employed must complete question No. 1 and sign this form certifying the number of hours that you were employed in a social work position. If yes, the LCSW supervisor may complete and sign this form.

1. Dates employed in a social work position: _____ to _____
Number of hours per week: _____
Total number of hours: _____
(One year of LCSW supervision is equivalent to 2,000 hours)

2. Supervision provided included the following:

_____ Number of hours individual LCSW supervision per week
_____ Number of hours group LCSW supervision per week

3. Content areas of supervision: _____

I certify the information provided is accurate to the best of my knowledge.

(Signature of LCSW Supervisor) Date: _____

(Signature of Agency Director) Date: _____